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ABSTRACT

Because of the relatively high rate of drug use among American Indian adolescents, this project was planned to survey the use of drugs, especially inhalants, by American Indian children aged 9-12. As a means of gathering data, interviews were rejected in favor of a simply-worded survey administered to over 1000 children in 9 Southwestern tribes. Significant drug use existed among the children. By age 12, they had used marijuana, alcohol, and inhalants more than the average for a national sample of children aged 12-17. Nearly 5% were heavily involved in using more than one drug; another 13.8% used a single drug regularly: and 4.2% used some alcohol. Experimentation with pills was high among heavy users. Cigarette use was also high among heavy users, but 7% of those who used no drugs smoked at times. Significant correlates of drug use among the children were peer attitudes, community attitudes, family stability, identification with American Indian culture, deviant attitudes and behaviors, personal attitudes, school adjustment, and future expectations. The questionnaire (included) is reliable and valid. Its internal consistency is high. Except for the cultural identification questions, it is suitable for any group of children aged 9-12. (SB)

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DRUG ABUSE AMONG INDIAN CHILDREN

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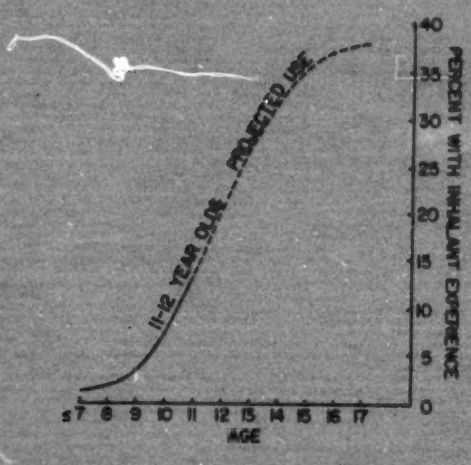

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INHALANT ABUSE AMONG YOUNG NATIVE AMERICANS
INTERIM REPORT

APRIL 1980

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OVERVIEW

This interim report on drug use among 9 to 12 year olds is part of a series of in-depth studies about Native American drug use. These two overview pages are a brief summary of the report. The boxes on the right line up with tabs which locate further information on each subject. The tab just to the right, for instance, locates the pages that list the overall goals of the grant and states how each goal was met. For example, two methods for obtaining drug use information from young children were tried: interviews and paper and pencil surveys. Interviews were too costly and impractical. A properly constructed survey proved to be more feasible and reliable.

Meeting the Project Goals

As part of a continuing study, this project grew out of a series of previous studies in which we looked at drug use by Native American adolescents. This review of our studies shows that they have a far higher rate of use for nearly all drugs than do young people from a large national sample. By the time these children were 13, when we began our study of them, many had already been using drugs for some time. This project, therefore, was planned to develop and test methods for surveying drug use by younger children, from 9 to 12 years old.

Review of Our Previous Studies

The present study, using a sample of over a thousand Native American 9 to 12 year olds, shows that drug use is high among these children. There are no national data for young children, but charts of drug use by age show that by the time these children were 12 years old they had used marijuana, inhalants, and alcohol more than the average for a national sample of children who were much older, 12 to 17 years old. Use of cigarettes is also very high and is correlated with other drug use. Many of these young children who are involved heavily with other drugs are also beginning to experiment with "pills." The tab to the right locates further details, including discussion of the implications for future drug use.

Drug Use by Young Native American Children

The appendices appear in a separate volume, and include more detailed statistical analyses of interest primarily to researchers. They include data on cluster analysis results, on the reliability of the survey items, and tables showing very detailed breakdowns of relationships between drug use and correlates from the survey. The appendices volume is available on request from:

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The survey also included a number of measures of potential correlates of drug use. The results suggest that all of the following are important in understanding drug use among young Native American children: the community, cultural identification, the family, the school, peers, emotional problems, expectancy about the future, attitudes toward drugs, and deviant attitudes and behaviors.

Correlates of Drug Use

A copy of the children's survey is located by this tab. The survey uses simple words, short sentences, and asks for simple responses. It is reliable and valid. Internal consistency is very high and the relationship between patterns of drug use and personality and social correlates are orderly and meaningful. Except for the specific questions about cultural identification, it should be suitable for use with any group of children approximately 9-12 years old.

Children's Drug Use Survey

MEETING THE PROJECT GOALS

Five objectives were proposed for this period of work, from January 1978 to June 1979:

1. To develop survey procedures that can be used with pre-adolescent Native American children to directly measure inhalant use.

   We tried two different methods of assessing drug use by 9-12 year old children, an interview method and a paper and pencil survey method. At the end of this section is a discussion of the interview method. It was found to be both impractical and uneconomical. The paper and pencil survey, by contrast, proved to be feasible and far more reliable than we had expected. With proper construction of a survey to keep it readable, we recommend this method of obtaining drug information without hesitation. The section of this report with the tab labeled CHILDREN'S SURVEY provides a copy of the final form of the survey. Data on reliability of the items appears in the Appendix to this report.

2. To pilot study the epidemiology of inhalant use.

   The children's survey was pilot tested in two smaller samples and the final form was then administered to over a thousand Native American children 9-12 years old. The results appear in the section with the tab labeled DRUG USE.

3. To relate inhalant use to other drug use, personality characteristics, social surround, and cultural identification of young Native Americans.

   Questions related to these areas and suitable for children were included in the survey. The section of this report labeled DRUG USE shows the relationship of inhalant use to the use of other drugs. Generally, inhalant use by young Native American children is part of a pattern of polydrug use. Children who use inhalants more than just one or two times are also very likely to use alcohol and marijuana. The section of the report labeled DRUG USE CORRELATES relates drug use to psychosocial characteristics and cultural identification. There are a number of significant correlates that are described in some detail.

4. To describe the development of inhalant use.

   The section on DRUG USE CORRELATES discusses some of the potential precursors of children's drug use.

5. To seek evidence that inhalant use is presently changing.

The section of the report labeled DRUG USE discusses present and future patterns of use of three drugs, inhalants, alcohol, and marijuana. Trends in the data indicate that inhalant use may have peaked among Native American youth. Alcohol use is still increasing slightly, but marijuana use may increase radically during the next few years.

Summary of the current status of our work:

1. A highly reliable and valid adolescent drug use survey is available for use by Native American tribes and schools.
2. The survey includes social surround, cultural and attitudinal scales that correlate with drug use.
3. A similar children's survey is completed and available for use with 9-12 year olds.
3. The following publications are available:

Beauvais, F., Oetting, E. R., and Edwards, R. A Case Study of a Drug Using Native American Child. (Submitted for publication.)

Oetting, E. R. and Goldstein, G. S. Drug Abuse Among American Indian Adolescents: A Final Report. Colorado State University. Fort Collins, 1975. (NIDA Grant #DA 01054-01-S1)

Oetting, E. R. and Goldstein, G. S. Native American Drug Use. Colorado State University. Fort Collins, 1978. (Final Report, NIDA Grant #2R01 DA 01054)

Oetting, E. R. and Goldstein, G. Drug use among Native American adolescents. In G. Beschner and A. Freidman (Eds.) Youth Drug Abuse. Lexington, Mass. Lexington Books, 1979.

Oetting, E. R., Edwards, R., Goldstein, G., and Garcia-Mason, V. Drug use among adolescents of five southwestern Native American tribes. The International Journal of the Addictions, 1980, 15(3), 449-445.

Goldstein, G., Oetting, E., Edwards, R., and Garcia-Mason, V. Drug use among Native American young adults. The International Journal of the Addictions, 1979, 14(6), 855-860.

Oetting, E. R., Goldstein, G., Beauvais, F., and Edwards, R. Drug abuse among Indian children. Colorado State University. Fort Collins, 1980. (Interim Report, NIDA Grant #1R01-DA 01853)

Oetting, E. R., Beauvais, F., Edwards, R., Velarde, J., and Goldstein, G. Drug use among Native American youth. (Submitted for publication.)

Use of interviews to obtain drug use data from young Indian children.

We had planned several stages to develop a successful interview method for use with young Native American children. The very first step that we took suggested that there were severe obstacles and the cost of successful interviewing would be prohibitively high.

We developed a preliminary interview aimed at collecting only a minimal amount of information from the children. We used this interview to develop methods for obtaining access to the children and to study the accompanying problems. We tried two methods, in-home and at-school. Each of the methods presented serious problems.

In-home interviewing. We tried the in-home interviewing on a part of the Navajo reservation where we had done considerable work on a previous project. We knew the locations of the children's homes and had a good relationship with parents and school authorities. A Native American familiar with the area was trained to do the interviews. They were done during the summer, when children should have been at home.

The size and lack of communication on the reservation made the task so costly that it was clearly infeasible. We had purposely picked an area where we knew there would be problems,

but we had not expected that they would be this severe. The interviewer had to stay in Window-Rock, drive 40 miles each day to the area being surveyed, and then drive on dirt roads to the home. There are no phones in these homes, so previous arrangements could not be made. If it did not rain and if the roads had not changed so that the map was still accurate, he could find the home. Then, if the child and parents were both home, an interview could be obtained. In ten days of work only three interviews were completed. This approach might be workable for tribes that are more geographically centralized, but the procedure would eliminate far too many study sites from our project.

At-school interviewing. We tried the at-school approach in a different location. With the assistance of the school administration, students were taken out of class and interviewed. The interviews proved very unsatisfactory. A few students would open up and tell us about their drug use, but many clearly did not trust the interviewer. Within a few days, the students coming in had heard so much about the interview from other students that we were getting rehearsed and stereotyped answers, not honest responses.

The development of the children's paper and pencil survey was taking place in parallel with tests of the interviewing

method. At this point we administered the children's survey in a pilot test and checked for consistency of their responses. The results were very encouraging. Internal consistency was very high, suggesting that the children could read the items and were responding accurately and honestly. We stopped interviewing at this point and shifted our efforts entirely to the paper and pencil survey.

Problems with the interviewing method can be overcome. We established a good relationship with older students in other schools and got honest and open discussion of their drug use and drug problems. We did this by first meeting with student groups to discuss the paper and pencil drug use survey with them. We then asked their advice about giving it and took their suggestions. They learned that we were not part of the school or local authority structure, and spread the word that we were doing good things and could be trusted. We felt confident that the same kind of process could be used with younger children and would probably be successful.

But the cost of this method is still high. An interview takes much longer than filling out a questionnaire, and all of that time must be spent by a well-trained, thus highly paid, person. A highly productive day results in 6 or fewer interviews. If a small random sample were to be used to estimate

overall drug use, a team of interviewers could use this method. The kind of analyses that we are interested in, however, require data from a large proportion of the students.

The interview method can be used for special purposes. We may return to it, for example, to get enriched case study material. We may also use it to explore further some clinical impressions derived from the survey data. It is not cost-effective, however, when compared with the paper and pencil survey method.

PREVIOUS STUDIES

This section of the report is a summary of our previous studies of drug use among Native American youth. The results of those studies show a high level of drug use among adolescents and young adults, but they also show that many young people start to use drugs before adolescence. In order to find out what was happening in the preadolescent years, we had to develop surveys that could be taken by younger children--that was the goal of the present project. The following review of the work that led us to this point begins with a brief statement describing what it is like to be a young Native American. Following that is a summary of the results of earlier studies.

The Problems Faced by Native American Children

Native Americans are among our country's most disadvantaged groups. They are often impoverished and live in areas of little economic consequence. There is a high level of unemployment and what money there is does not go very far because of isolation and the high distribution cost of staples.

Physical isolation also means limited cultural and entertainment opportunities, particularly for children. Playgrounds, movies, hobby shops, libraries, and other facilities are often

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inaccessible. Even when the children can reach them, the communities that are nearby frequently present an attitude of direct prejudice, not significantly reduced by the recent wave of concern with "racial equality."

School is also a problem for these children. Many must leave home to live in boarding schools from the age of six or seven. Others commute long distances on buses. But even children who live near schools have problems. These children often speak a Native American language in their homes, but have to use what is to them a foreign language, English, in the school. Furthermore, while there are some dedicated teachers, the isolation and limited opportunities for advancement mean a high rate of turnover, thus frequently exposing children to inexperienced teachers.

There are other conditions disrupting these childrens' lives. Family structures may be unstable; one or both parents may be missing from the home; the suicide rate is very high, and alcoholism is a widespread problem among Native Americans generally. It is not hard, then, to understand why some children facing these kinds of problems would seek through drugs a temporary release from the chronic problems of living.

Summary of Our Previous Studies

When we first started work in 1973, there were very few studies of drug use that involved Native Americans. The studies that were available suggested a higher than average use of drugs (2, 6), but included very limited samples. Our first studies were aimed at developing an adequate survey that could be used with Native American adolescents: one that would reliably evaluate drug use and some of the critical personal and social correlates of that use.

In constructing, testing, changing, and retesting the survey, we found that the critical problem with most surveys, including our own early forms, was a tendency to use questions that were too complex and too indirect. After several trials, the data showed that we had a survey that students could respond to accurately and consistently. During 1976 and 1977 we were able to test our survey while helping a number of different tribes and Native American schools assess their childrens' drug use. While we were not trying to construct a representative sample, it nevertheless came close to one since the children came from a number of different tribes distributed across the country. Consequently, we not only tested the reliability of the survey, but also put together a sample that allowed us to compare Native American drug use with a

representative survey of other youth. The findings were reported in our last final report. They are summarized in the following table:

Table 1

Comparison of Drug Use by Native American Youth with Other Youth

Drug	Lifetime Prevalence		Recent Use	
	Native Americans	Other Youth	Native Americans*	Other Youth**
Marijuana	46.4%	28.2%	40.5%	16.1%
Inhalants	22.0%	9.0%	15.5%	.7%
Stimulants (uppers)	14.7%	5.2%	7.8%	1.3%
Tranquilizers (non-medical)	8.5%	3.8%	***	.7%
Hallucinogens	13.2%	4.6%	***	1.6%
Cocaine	7.5%	4.0%	***	.8%
Sedatives (non-medical)	10.2%	3.1%	4.8%	.8%
Heroin	3.8%	1.1%	***	.5%
Alcohol	78.3%	52.5%	61.0%	22.3%

*During Last 2 Months
**During Last 1 Month
***Data Not Available

The table shows that a significant segment of Native American youth have a far higher rate of experimentation with drugs than do the young people from a large national sample. As with other youth, alcohol and marijuana are tried most often. The next most frequently

used type of drug is inhalants. The difference between Native American use of inhalants and that of other young people is exceptionally high. Not only have twice as many tried inhalants, but a far larger number are continuing to use them. Almost none of the other young people who had tried inhalants used them during the last month, while a very large proportion, nearly three-fourths, of the Native American children who had tried inhalants had also used them recently. Other drugs show a similar pattern, with many more Native American children trying the drugs and continuing to use them. Our last final report, "Native American Drug Use," 1978, provides further details.

When we chart drug use by age in Table 2, it is apparent that drug use increases steadily with age through the high school years. As the table shows, even by the age of 13, where our tables start, many children are already using drugs. Other information suggested that drug use for these young children was also increasing more rapidly than it was for older children. We decided that in order to fully understand the use of drugs by Native American children, we would have to find out about this early drug use. However, younger children clearly could not take the complex and long survey that we were using with adolescents. The project described in this report, therefore, was designed to develop and test survey methods that would let us find out about drug use by younger Native American children.

Table 2

Percentages of Adolescents Reporting Having Tried a Drug by Age

	13	14	15	16	17	18
Beer	68.1%	76.9%	79.5%	83.6%	84.5%	91.7%
Wine	38.4%	44.8%	46.7%	51.0%	54.6%	56.1%
Liquor	41.8%	54.3%	53.0%	61.2%	67.8%	75.5%
Inhalants	21.4%	23.5%	22.3%	18.8%	19.9%	19.9%
Marijuana	49.5%	56.6%	58.2%	63.6%	62.4%	63.5%
Amphetamines	9.6%	11.2%	16.4%	20.5%	22.9%	22.9%
Barbiturates	7.1%	8.5%	11.2%	9.6%	9.9%	12.2%
Tranquilizers	10.8%	15.3%	12.6%	15.8%	17.8%	15.7%
Heroin	4.5%	3.5%	3.8%	2.7%	3.2%	3.2%
Cocaine	5.8%	8.2%	6.2%	12.1%	9.2%	10.6%
Peyote	3.2%	6.4%	6.6%	8.3%	10.3%	9.9%
LSD	5.6%	7.1%	8.9%	13.7%	15.4%	11.6%

EXTENT OF DRUG USE BY YOUNG NATIVE AMERICAN CHILDREN

Developing the Children's Survey

A Children's Survey was developed from the adolescent survey. Simpler words were used where possible. The survey was also shortened considerably while trying to retain critical items. It was pretested and rewritten twice. This survey was then given to slightly over a thousand children from nine Southwestern tribes. Our main goals were (1) to test the survey in order to make sure that it was working with young children and (2) to provide the tribes with information about drug use by their children.

A few further minor changes were made in the survey based on the results of this study. A copy of the final form of the survey appears in the section with the tab CHILDREN'S SURVEY. The survey is reliable and the results are consistent enough so that we feel it is giving us an accurate picture of drug use. While designed for use with Native Americans, it would be suitable for any group of children from 9-12 years old. It takes less than an hour to complete. Only the questions about Native American identification would have to be changed or eliminated.

Drug Use By Native American Children

Beyond meeting these goals, the data also give us some idea of the extent of drug use by young Native American children. This sample is only a small one and it was taken from

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tribes in only one part of the country. It does not, therefore, tell us what the level of use is nationally. But when we surveyed the older children in these same tribes, their level of use was slightly below the national average for Native Americans. So our best guess is that these results may slightly underestimate actual use by Native American children.

The survey asked about only three types of drugs: alcohol, marijuana, and inhalants. It was limited to these drugs because previous studies of drug use by children have shown that very early drug use is almost always limited to these drugs. We included an item on "pills" to assure that we would not miss a change in pattern toward use of other drugs.

The table below shows the extent of drug use by these Native American children: how many children in each age group have tried the drug. There is no national information on the use of drugs by children this young, consequently direct comparisons of Indian and other children are not possible. But indirect comparisons can be made. The table includes analogous information about adolescent drug use, both from our previous work with Indians and from a national survey.

Comparing the use of drugs by Native American 12 year olds with the national average for older children is informative. By the time they are 12, the pattern of Native American drug

Table 3

Lifetime Prevalence of Drug Use by Young Native American Children from Southwest Tribes, 1978-1979

Ever Tried	Age 9	10	11	12	Lifetime Prevalence: 1977 National Data Native Americans 12-17**	Other Youth 12-17
N =	262	358	307	139	2,904	1,272
Alcohol	17.2%	29.3%	32.6%	54.0%	78.3%	52.6%
Marijuana	10.6%	20.4%	22.4%	41.7%	46.4%	28.2%
Inhalants	4.2%	6.9%	8.8%	15.1%	22.0%	9.0%
"Pills"	.8%	2.3%	5.5%	1.4%	--	--

**A few children were under 12 or over 17 in this sample.

use looks more like that of other children who are 15 or 16 years old.

In interpreting this table, it is important to know that even though a lot of young children have tried drugs, most of this use is very light. For example, among 9 year olds, 17% have tried alcohol, but 75% of these children have just tasted it--they have not really used alcohol. A high percentage of children who have tried drugs, therefore, does show that drugs are available and that children are trying them, but it does

not necessarily mean that all of the children who tried it are using a lot of that drug.

But the results should not be minimized, either. There is substantial drug use, even among very young children. For example, 10% of 9 year olds have tried marijuana. Obviously marijuana is available to these very young children, and quite a few of them are trying it. Furthermore, half of the children who have tried it have used it more than three times. That is a lot of drug involvement for children who are only 9 years old, and it is only a beginning. The table shows that with every year that passes more children will try drugs.

Previous studies had prepared us for the high level of inhalant use. Inhalants are always available and are used by many Indian children.

As we further expected, nearly all drug use at these ages is of alcohol, marijuana, and inhalants. These are the drugs of choice for very young children. A few children have taken some kind of "pill," and some of these children wrote in "upper" or "downer." But this use is still rare. The discussion on patterns of drug use that appears later in this section shows that the children who are using "pills" are those who also use heavily both marijuana and inhalants.

Future Trends for Drug Use by Indian Children

Before we had any actual surveys of younger Indian children, we had estimated the extent of child drug use by asking adolescents when they had started using alcohol, marijuana, and inhalants. The following graphs show that with every passing year drug use is beginning earlier and is increasing at a higher rate. The Children's survey finally gives us a chance to directly verify what we had found. The results show that our previous findings were all too accurate.

Use of Alcohol

Alcohol is the most frequently used drug by young Native Americans, and the graph shows that its use is still increasing. The actual use of alcohol by children 9 through 12 years old is higher than that shown by any group of children from our previous studies. Since these young children are from tribes where the adolescents did not show an above average rate of drug use, there has probably been another increase in alcohol use by young Indian children in general. (See Figure 1)

Use of Marijuana

Marijuana use by younger children, like alcohol, is still going up. Its use is higher than it was a few years ago, and it looks as if it is starting even earlier. As the graph

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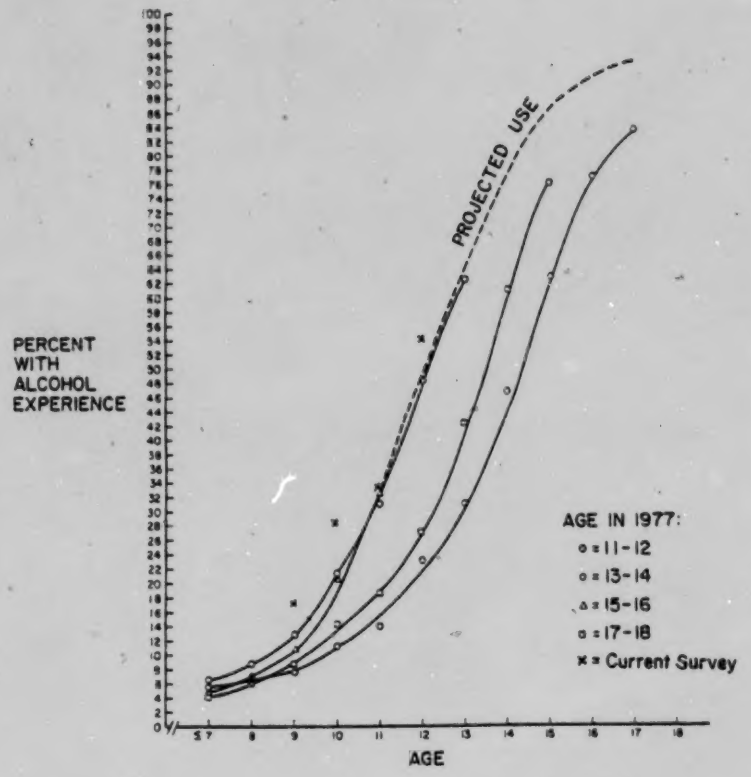

Figure 1

Reported Age of First Alcohol Use for Different Age Groups

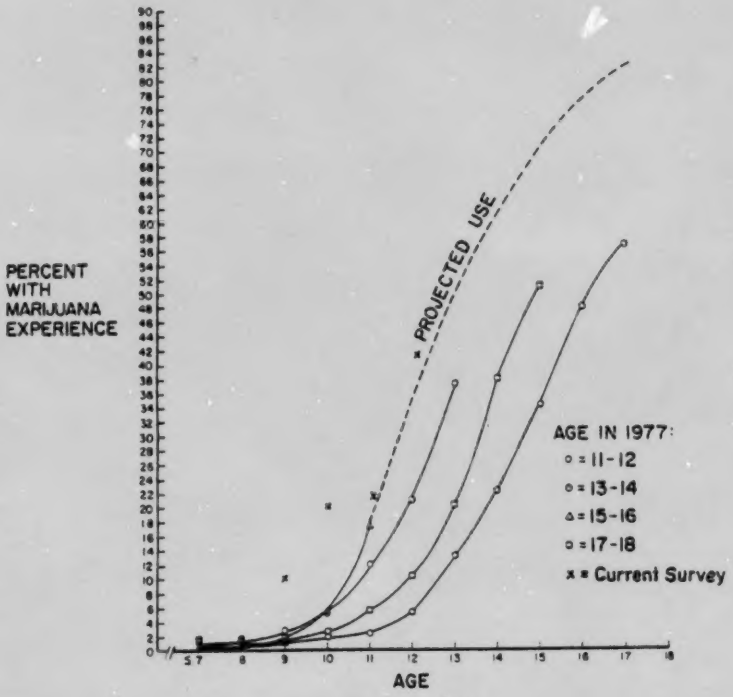

Figure 2

Reported Age of First Marijuana Use for Different Age Groups

shows, before 1977 only a few adolescents reported beginning to use marijuana at age 9. In 1978, we find that 10% of 9 year olds have tried marijuana. (See Figure 2)

Use of Inhalants

The graphs show that inhalant use among young children has increased very rapidly during the last six to eight years. As with alcohol and marijuana, children were starting younger, and more of them were getting involved with inhalants with every succeeding year. But unlike alcohol and marijuana, the use of inhalants may have finally reached a peak; it is no longer increasing among very young children. The "use by age" graphs for younger children for 1975, 1976, 1977, and 1978 are all about the same. (See Figure 3)

This is encouraging news. But it is not good news, because the use of inhalants is still very high. Fortunately, however, it does not seem to be getting worse. This finding, that inhalant use has peaked, agrees with national trends. In general, inhalant use is no longer increasing in this country among children of any group.

Implications for Future Drug Use

If alcohol and marijuana use are still going up and inhalant use has stabilized among younger children, what can we predict about adolescent drug use during the next few years?

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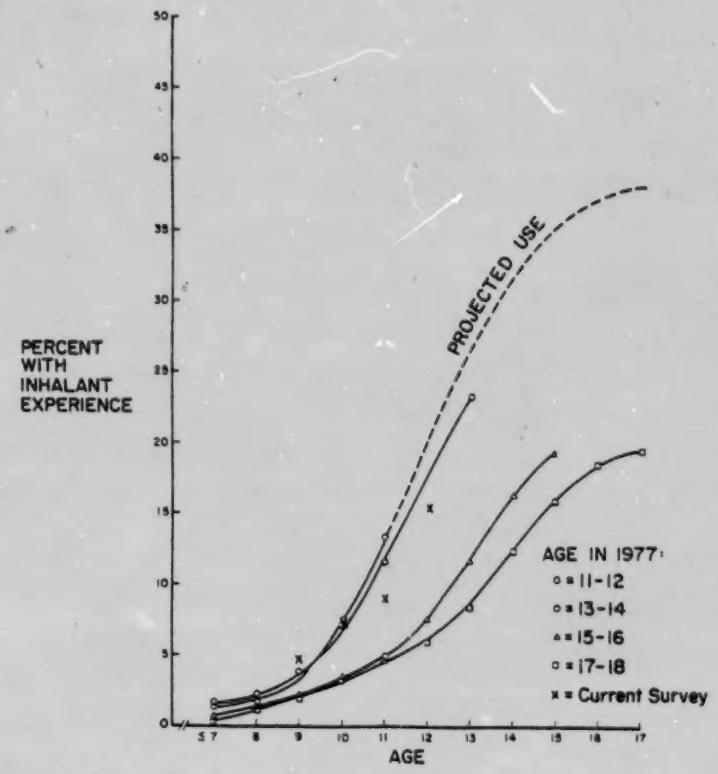

Figure 3

Reported Age of First Inhalant Use for Different Age Groups

If we start with our earlier data, we can build a formula that shows how early drug use translates into later use of drugs. We can then apply that formula to the data on drug use by young children and predict what they will be doing a few years from now. The prediction, of course, depends on the conditions that will apply during the next few years. If effective prevention programs are established for Indian youth, the rates might be

lower. If economic or political conditions get worse for Indians, the rates might be higher. But if things stay much as they are at present, the predictions may well be accurate.

Figure 4 shows what we can expect Native American adolescent drug use rates to be through 1986. We predict that alcohol use will increase for a while but stabilize around 1983. Inhalant use will increase for the next few years as older children, who tended to use inhalants less, grow up and leave school. But this rate will stabilize by 1981, and there may even be a slight decrease after 1983. The slight decrease appears because the present use by 11 and 12 year olds is very slightly lower than that found two years earlier.

The picture for marijuana use is very different from that of alcohol and inhalants. It increases rapidly and keeps on going up until it is almost as high as alcohol use. Although predicting this great change in the relative use of alcohol and marijuana may seem very radical, the data of the children's drug survey make this trend clear.

These results for marijuana seem to contradict some recent findings for other youth. A few people have suggested that use of marijuana by other youth has stabilized and is no longer increasing. After getting results that suggest marijuana use among Indian children is going to get much higher, we checked

with a number of other researchers who are knowledgeable about drug use. Some of them feel that the idea that marijuana has stabilized is premature. They feel that its use is still increasing even among other young people and were not at all surprised by our projections.

During the next few years we will be carefully monitoring the relative use of these three drugs to see whether the predictions are accurate.

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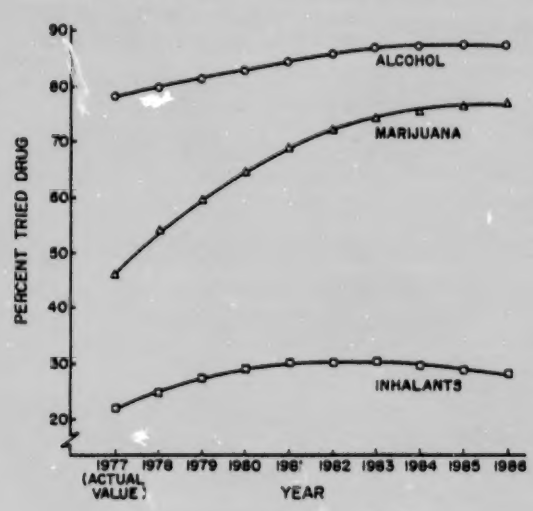
Figure 4

Projected Drug Use Through 1986: Average Rate of Lifetime Prevalence for Native American Adolescents 12-18 Years Old



Types or Patterns of Drug Use

The previous section discusses children's use of individual drugs; alcohol, marijuana, and inhalants. Some children use all of these drugs; others use only one. Some children use a drug several times a week; others have just tried something

once or twice. In order to really understand the problem, we need to know how children use drugs, their overall pattern or type of drug use.

We organized these types or groups by identifying similar patterns of drug use, then checking to determine (1) whether each group was distinctively different from its neighboring groups, and (2) whether the children within the group were alike in the way that they used drugs. If neighboring groups were not different, they were combined. If children in a group were not enough alike, the group was divided into two separate groups. This process was repeated until the structure of the groups was clear. Then a final check was made to assure that the types of drug use were logical and reasonable given what we already knew about drug use among Native American children.

For example, among the 14 types or patterns, there are two groups of children who are the most heavily involved with drugs. One we have labeled the "heavy child polydrug group," the other, the "child polydrug group." The two groups are slightly different in how they use drugs. In the former group children get drunk more often and are more likely to use inhalants until they almost pass out. Children in the latter group drink with friends quite a bit, but are less likely to get drunk and are more likely to use inhalants only until they "feel it a lot." When

we are describing drug use problems to treatment or prevention people, it is helpful to talk about how many of each of these groups are present in the community.

Notwithstanding these differences, the two groups also have much in common; children in both groups use alcohol, inhalants, and marijuana. Furthermore, the numbers in each group are small and present problems for statistical analysis. For some analyses, therefore, the groups are combined into an overall type labeled "child polydrug."

The chart on the next page shows the types of drug use found among these Native American children like the two child polydrug types just discussed. The types range from the most serious, to moderate use, to no use at all. Every child can be assigned to one of the types and is assigned by finding the highest (most serious drug use) group to which that child belongs.

A table is provided that describes each of the patterns of drug use in detail (page11, Appendix II). In general, the groups have the following characteristics:

Table 4

Children's Drug Use Types and How Types are Combined

Type	Percent of Total Group
POLYDRUG	
1. Heavy Child Polydrug	2.0%
2. Child Polydrug	2.6%
DRUG INVOLVED	
3. Marijuana and Alcohol	2.8%
4. Marijuana	3.0%
5. Inhalants	1.4%
6. Light Marijuana and Alcohol	3.3%
7. Light Marijuana	3.3%
ALCOHOL	
8. Alcohol	1.6%
9. Social Alcohol	2.6%
NOT DRUG INVOLVED	
10. Tried Marijuana	3.0%
11. Tried Inhalants	.5%
12. Family Alcohol	1.8%
13. Tried Alcohol	8.1%
14. No Use	54.5%
INCONSISTENT RESPONDERS	9.5%
	100.0%

The child polydrug pattern (types 1 and 2 on chart preceding page) involves use of both inhalants and marijuana. They have not just tried the drugs; they use them fairly often. Many of the children, particularly in the heavy child polydrug group, also use alcohol frequently enough to get drunk. Many of these children have also taken some kind of illicit pill.

The high drug involvement groups (types 3-5) are more specific in their use of drugs. They do not use both inhalants and marijuana, but use one or the other. They are involved in continuing use of the preferred drugs.

The light drug involvement groups (types 6 and 7) are only using marijuana a few times a year.

In any of these groups where the term "alcohol" appears (types 3, 6, and 8) it means that the children in that group have used enough alcohol to get drunk and are continuing to use alcohol.

With the other two alcohol groups, matters are different. The children in the "social alcohol" group (9) use alcohol with their friends, but not enough to get drunk. The "family alcohol" group (12) uses a little alcohol, but not enough to get drunk and only with family members.

The three groups labeled "tried" (10, 11, and 13) have all tried that particular drug, but are not using it now.

The "no use" group of children have never tried alcohol, inhalants, or marijuana.

The children in the High Drug Involvement groups (1-5) who use marijuana tend to use it often, many of them at least weekly, and quite a few smoke it alone as well as with other kids. Such frequent use suggests that it is meeting strong needs of some kind. The needs may be social, something that one "just does" with friends. But if so, then their friends are also using drugs and over the years the drug use is likely to increase through social pressure. Most children use marijuana in a social setting, with other kids. Using marijuana alone suggests that the child is not just responding to social pressures, that it makes the child feel better in some way, that a physical or emotional need if being met. That too is an indication of a serious problem that is likely to lead to increasing use.

The involvement with drugs of the children in the lighter use groups is serious in two ways. In some groups, children are already using drugs quite frequently, particularly marijuana. In others, while the use is still low, it is occurring among very young children and shows an already existing interest in or even fascination with drugs. With years of increasing exposure to drug use ahead of them, they are at considerable risk: they are very likely to become more seriously involved as they grow older.

Although there is a group that uses marijuana quite heavily and does not get drunk on alcohol, most of the children using marijuana also use alcohol. If they use marijuana, they are likely to have used enough alcohol to get drunk at some time. Alcohol is not being used in a purely social way--it is being used as a drug. And it is likely to continue being used as a drug.

Overall, the drug use groups are consistent with those of older Native American children. Some children, the polydrug group, are heavily involved with drugs, using essentially whatever they can get hold of. Others use marijuana quite frequently, and most of these also use alcohol occasionally to get drunk. There is a group of children who do not use other drugs, but who will use alcohol with their friends to get drunk. All of these early patterns are serious, especially because they are occurring so early. And they are consistent with later patterns of drug use by adolescents; further, they may predict what is going to happen to these children in the future.

As the patterns make clear, there is significant child drug use. That, by itself, may be the most important finding. The patterns are being set in children as young as nine years old and prevention and treatment programs need to consider use of drugs by young children as well as the more apparent use by older adolescents.

The Use of "Pills"

The standards for looking at drug use by younger children suggest that questionnaires be limited to alcohol, inhalants, and marijuana: that these drugs are the only ones used significantly by children.

While they are the most used drugs, we knew that there was some other drug use even by young children and that it might be increasing. We did not want to include a long "shopping list" of drugs on the children's survey partly because of the need to keep the length of the survey down and partly because we felt it somewhat inappropriate to suggest to children that they might use these drugs. We have found that nearly all children knew about marijuana and inhalants, so were not too concerned about asking about those drugs. We did, however, avoid providing a suggestive list of inhalants for the same reason that we did not specify "pills."

Two very general questions were included in asking about use of "pills." There was some misunderstanding of the questions. Some children thought of aspirin, vitamins, or cold medicines as "pills." But many other children listed "uppers," "downers," and "LSD," as pills that they had taken. After eliminating all responses that indicated misunderstanding, there was still a significant amount of "pill" use.

Nearly all of that use was experimental; children had only tried these other drugs once or twice. Still, that some of these very young children are already experimenting with other drugs is significant in itself. The percent of each drug group who have experimented with "pills" is listed in the following table:

Table 5

Percent of Children Trying Illicit "Pills" in Each Drug Use Group

Drug Use Group	Percent
Heavy Child Polydrug	57%
Child Polydrug	24%
Marijuana and Alcohol	6%
Marijuana	3%
Inhalant	0%
Light Marijuana and Alcohol	5%
Light Marijuana	8%
Alcohol	0%
Social Alcohol	0%
Tried Marijuana	0%
Tried Inhalants	0%
Family Alcohol	0%
Tried Alcohol	0%
No Use	0%

Nearly all of the use of "pills" is limited to those children who are already involved with drugs, children in the polydrug patterns, and those using marijuana. Most of the use is by those children who are in the polydrug patterns. More than half of those

children in the "heavy child polydrug" group and a quarter of those in the "child polydrug" group have taken some kind of pill. This finding tends to confirm our use of the term "polydrug" for these two groups of children: they are not only involved with multiple childhood drugs--alcohol, marijuana, and inhalants--but are already experimenting with other drugs.

It is interesting that those inhalant users who are not using marijuana also do not use pills. This may be a matter of age. More of these inhalant users tend to be very young.

It is clear that surveys of younger children are going to have to consider use of drugs other than the dominant three. Thus far the use of "pills" is only experimental, children trying them once or twice, so simple questions like the ones we used are still suitable. But the situation needs to be carefully watched. If use of other drugs increases, it will need to be considered in future children's surveys, and questions will need to be incorporated that are more specific.

The Use of Cigarettes

There is considerable use of cigarettes among the children in our sample. 39.4% have tried smoking and 3.9% list themselves as smoking "a lot." We had only one question on the survey relating to cigarettes, so there is no information available about exactly what these children mean by "a lot." But we can say with certainty,

as with other drugs, that the older the child, the more likely that child is to have tried smoking (Table 6).

Table 6

Use of Cigarettes by Age

	Age			
	9	10	11	12
Percent "never tried"	78%	63%	59%	35%
Percent "tried"	7%	17%	18%	28%
Percent "a little"	10%	16%	19%	32%
Percent "a lot"	4%	3%	4%	5%
Total percent who smoke "a little" or "a lot"	14%	19%	23%	37%

Smoking is also related to the pattern of drug use. The more seriously a child is involved with drugs, the more likely that child is to use cigarettes as well. In fact, the percent who smoke (the last column in Table 7) is directly and almost perfectly related to the level of drug use. Nearly all of the children, for example, in the Heavy Child Polydrug pattern also smoke, many of them "a lot." But smoking is not limited to the children in the heavier drug use groups. Quite a few children in groups where there is little or no drug use have experimented with cigarettes (Table 7).

While we have been primarily concerned with the use of other drugs, it is clear that cigarette smoking is going to be relatively

frequent among these children when they are older. Its occurrence in otherwise drug-free groups indicates that it is not considered to be a drug, or at least not a very serious one. The "no use" group, for example, consists of about 600 children who have never even tried a taste of beer; 7%, or 42 of these children, smoke a little. This casual attitude toward cigarettes suggests that smoking may be a serious health problem when they grow up. It may, in the long run, do as much damage as some of the supposedly more dangerous drugs.

Table 7

Use of Cigarettes by Children in Drug Use Groups

		% Never Tried	% Tried	% "a Little"	% "a Lot"	Total % Who Smoke
1.	Heavy Child Polydrug	9%	0%	39%	52%	91%
2.	Child Polydrug	7%	20%	60%	13%	73%
3.	Marijuana & Alcohol	16%	16%	62%	6%	68%
4.	Marijuana	24%	21%	44%	12%	56%
5.	Inhalant	19%	25%	38%	19%	57%
6.	Light Marijuana and Alcohol	8%	42%	45%	5%	49%
7.	Light Marijuana	13%	42%	42%	0%	42%
8.	Alcohol	39%	28%	22%	11%	33%
9.	Social Alcohol	37%	30%	33%	0%	33%
10.	Tried Marijuana	38%	38%	21%	3%	24%
11.	Tried Inhalants	33%	50%	17%	0%	17%
12.	Family Alcohol	60%	30%	10%	0%	10%
13.	Tried Alcohol	41%	40%	19%	0%	19%
14.	No Use	86%	8%	6%	1%	7%

Implications of the Child Polydrug Pattern

While all types describe a pattern and carry implications, the child polydrug pattern is a new way of describing the drug use of a group of young children. It consists of considerable use of both inhalants and marijuana. But the implications go beyond the use of those drugs. By calling them a polydrug group we are indicating that these children are involved in the use of drugs as an important part of their life and that they are very likely to soon move into the adolescent polydrug pattern. There are already indications that this is happening. Nearly all of them already smoke cigarettes, and half of them have already tried some kind of illicit "pill," usually an upper or a downer.

About five percent of the children in this Native American sample fall into the child polydrug pattern. This is a large number of children to be so seriously involved with drugs.

CORRELATES OF DRUG USE

What causes drug use among these young Native American children? We began this report by listing some of the factors that make life difficult for them: poverty, prejudice, and cultural and emotional problems. But these are chronic problems for many Indian children. Why do some get deeply involved with drugs and why are others able to avoid drug use?

A series of questions were included on the survey to measure those characteristics of the children that might be related to drug use. From the literature and from our own earlier work with Native American adolescents, we decided what was important to measure. We then wrote items suitable for a children's survey that, theoretically, should relate to those characteristics.

The scores of children who had different patterns of drug use were then compared. The results are discussed in sections, each dealing with the following areas that we have isolated as being important:

Section	Page
The community	47
Cultural identification	52
The family	57
The school	73
Peers: friends, brothers and sisters	64
Emotional problems	77
Expectancy: what does the future hold?	82
Attitudes toward drugs	61
Deviant attitudes and behavior	61

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In any studies using survey data, even when there is a relationship between a characteristic of the children and drug use, it is hard to know just why that relationship occurred. The characteristic could be a cause of drug use. Equally, it could be a result of drug use, or something totally different could influence both the characteristic and the drug use. At this stage we have to use judgment to decide among these alternatives, judgment based on experience and logic.

Measuring Characteristics of the Children

Two preliminary forms of the Children's Survey were pilot tested. After each test, items were dropped, rewritten, and new items were added. The section of this report with the tab labeled CHILDREN'S SURVEY includes a copy of the survey and the items that were finally used.

After the survey was administered, cluster analyses were used to group the items into clusters. The statistical technique determines which items are measuring a common underlying characteristic. Then children who use drugs and those who do not can be compared based on their total score on the cluster of items.

Following is a greatly simplified example of how cluster analysis works. For further information, researchers should read Tryon and Bailey's Cluster Analysis, McGraw-Hill, 1970.

In Table 8 is a list of a few items taken from the actual survey. These are the items that were planned to measure attitude to deviance (whether the child thinks it is wrong to lie, cheat or steal), deviant behavior (whether the child actually does "bad" things), depression (feelings of being sad), and anxiety (feelings of being tense or nervous).

The cluster analysis first determines the overall pattern of correlations of each of these items with every other item on the survey. It then compares each item with every other item to find which ones have the same pattern of correlation. It groups together items that have the same pattern, and separates those that have different patterns.

Table 8

Sample Items from the Children's Survey

Cluster:	Deviant Attitudes
	Is it bad to tell a lie?
	Is it bad to skip school?
	Is it bad to steal?
Cluster:	Deviant Behavior
	I do bad things.
	I lie to people.
	I do things my teachers don't like.
	I cheat in school.
	I steal things.

Table 8 (continued)

Cluster:	Depression
	I'm lonesome.
	I feel bad.
	I feel sad.
	I am unhappy.
Cluster:	Anxiety
	I am nervous.
	I get tense and jumpy.

But this is only the first step. The cluster analysis then takes those items and plots them on a three-dimensional graph. It bases their position on that graph by relating each item to three different underlying factors. You can then see just how the items fall into clusters. The following page shows the result for these three groups of items. Each item is plotted on the surface of a sphere. If two items are 90 degrees apart (a quarter of the way around the sphere), they are essentially unrelated to each other. The closer two items are to each other, the more they are related to each other.

It is apparent on the graph that there are three clusters of items. Each cluster includes items that are quite close to other items in that cluster, and the clusters are separated from each other. Deviant attitudes is not related to either of the other clusters. Deviant behavior, actually doing "bad" things, is,

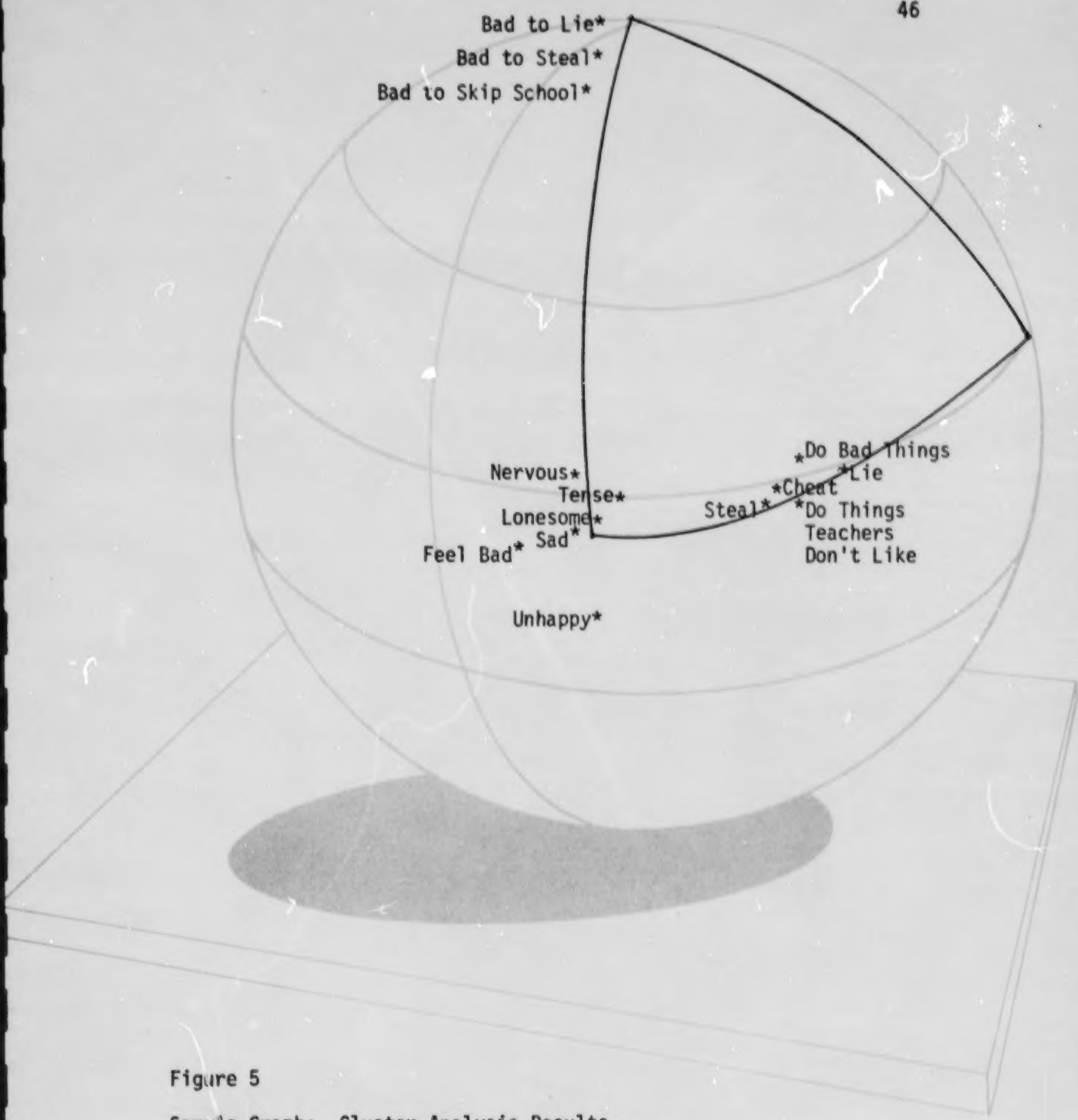

Figure 5

Sample Graph: Cluster Analysis Results

This diagram is provided as an example of the results of a cluster analysis. It shows how the three-dimensional graph can be used to decide what items cluster together. Items clustering together can be assumed to measure the same underlying characteristic. A total score on those items is then used in further analyses that relate that characteristic to drug use. The above graph shows three clusters: Deviant Attitudes, Deviant Behaviors, and Depression.

somewhat surprisingly, not related to whether the children think these things are wrong. It is likely that many children know they are wrong, but still do them.

The items that were meant to identify depression and anxiety cluster together. Apparently these children do not separate out these feelings. If they feel bad or sad, they also feel nervous and tense. One item, "unhappy," does not quite fit into the depression cluster. The other items are used together to assess a general feeling of depression.

The depression cluster and the deviant behavior cluster are related to each other: they are less than 90 degrees apart on the graph. Apparently those children who do act out are also more likely to have negative emotional feelings.

This section shows how we used cluster analysis to determine which items could be grouped together to measure a common underlying characteristic. Most of the following sections discuss the relationships between the item clusters and drug use.

The Community

This study was of individuals and not directly of communities; nevertheless, we have made some observations about the types of communities that are more likely to have severe drug use problems.

First, if there is a great deal of tension and stress among the adults in the community, the children are more likely to have

a heavier involvement with drugs. We are not talking about the normal political and personal conflicts, but about situations in which people have become very hostile and angry. If there has been a lot of recent internal strife, political battles that have aroused a lot of hostility or conflicts between groups with different goals, then children are likely to get more drug involved. We don't know why this occurs. The arguments among adults may make children feel insecure so that they turn to drugs, or the battles may simply keep adults so busy that they don't have enough time to spend with their children.

Communities where there are few alternative activities for young people are also likely to have a high rate of drug use. In a small Native American community, for example, the nearest town with a movie, library, gymnasium or drug store is more than 20 miles away. There is no local Boy Scout or Girl Scout troop. The trading post has a few comic books and plenty of candy, but they are very expensive. Children do take part in ceremonies and powwows, but these only happen a few times a year. Drug use among children is very high. On our surveys, many young people directly confirm the relationship between lack of activities and drugs when they state that they take drugs because "there is nothing else to do around here," or "because I'm bored."

If a tribe is isolated, drug use may be reduced somewhat. However, the effect may be only temporary; it just takes longer

for the new drugs to get there. But every drug seems to eventually become available even in the most isolated communities.

There is a further problem with isolated communities. There is usually little local opportunity for employment. Families may have to move back and forth from larger cities to the reservation. Children of such families can be very vulnerable to drug use. They have the additional stress of having to move, to adapt to a new school, and find new friends. Often, the cities where jobs are available to Native Americans are those with high rates of drug use. When they return to the reservation they may bring back knowledge of drugs and the drugs themselves. The isolation and the relative lack of other activities in the community then often lead to a very sudden epidemic of drug use. These epidemics are likely to involve a very large number of children using drugs, almost all of them in the same way. In one tribe, for example, nearly two-thirds of the children were using inhalants, but they were not using other drugs. Inhalants and ideas about how to use them had been brought back by a couple of influential junior high school boys.

No matter what the location of the reservation, a high level of concern and concerted action by adults may reduce the level of drug use. For example, in one community the adults organized an actual "sniff patrol." At noon and after school they took turns patrolling the school yards, playgrounds, alleys, and other places

where children had been using inhalants. They were able to reduce inhalant use, and, more than that, their actions showed other children how much the adults were against sniffing.

But a severely punitive approach can prove counterproductive. In a tribe where the police and school authorities were very strongly against drugs and where they punished those they found with even a little marijuana severely, there was a little less light drug use. But there was a higher amount of really severe drug use. 6 % of the children in high school were using uppers and downers, and most of these children were also using hallucinogens. It appears that the severe punishment had forced the drug-using children into a very close clique. They could not have other friends because they might be reported and caught. They spent more time together and apparently encouraged each other into increased use of drugs.

There are probably other characteristics of communities that are important. We are only now starting formal studies of those characteristics and will have much more information in the coming years. In the meantime, communities that are trying to do something about drug use should consider doing the following: First, make sure that there are alternative activities for children, things that are fun and are supervised. Make sure that activities are readily available at any time children are not at home or in

school. Second, consider the amount of conflict and strife occurring among adults, and try to make sure that the children do not become involved. Children are often expected to "take sides" when community divisions develop, and they become subject to the stress of conflict. Third, mobilize the community against drugs--watch for drugs and try to stop their use when you see it. Make sure that children know that adults are firmly against drugs. But do not overreact and excessively punish children who experiment a little with drugs. Many children will try drugs, particularly marijuana and inhalants, and there is little that can be done to stop this experimentation. It is more important to make sure that they do not go on to heavy use or even more dangerous drugs.

A final action to consider is controlling the source of drugs. Our surveys have shown that in some communities liquor stores are selling large amounts of alcohol directly to youngsters. In one location we also found an extremely high level of amphetamine use. The rate was so high that there was undoubtedly a large illicit source, perhaps the local IHS hospital. IHS physicians should be asked to more closely monitor their medications. This includes not only reduction of unnecessary prescriptions but also greater security of pharmacies. We know of one location where youngsters working in a hospital have virtually free access to pharmacy medications.

Native American Culture

The norms of Native American tribal cultures have, traditionally, included the use of drugs such as tobacco, peyote, and morning glory seeds. Traditional healers use a wise range of natural substances from corn pollen to plants that are still kept secret, although the Native American healer relies far less on the use of drugs than the non-Indian physician. Drugs are, therefore, a part of Indian culture, but all of these drugs are used only within rigidly prescribed religious, cultural and medicinal ceremonies. Even when social use of a drug has become extremely widespread, Native Americans have not accepted it as a part of their culture. For instance, alcohol use has been and continues to be very common, but it is still "officially" frowned upon. Many reservations still outlaw the sale of liquor and Nativistic movements, such as the Native American Church, the Ghost Dance religion and the Handsome Lake cult are strongly opposed to drug and alcohol use. Taking drugs has not been and is not a fundamental part of the Indian culture. Recreational drug use has been adopted from non-Indian cultures; it is not part of the Indian way.

We have, therefore, tried to find out whether a strong identification with Indian culture can help to protect a child from drug use. Several questions on the survey asked whether the child lived in the "Indian way" or in the "non-Indian" way.

Item clusters were obtained that showed a child's identification with both the "Indian way" and the "non-Indian way." The roots of this identification lie in the family. Children who live in the Indian way also have families that live in the Indian way and feel that their family is a "good one" in the Indian way. These children and their families also take part in Indian activities and events. The contrasting non-Indian way shows the same pattern. Children whose families live in the non-Indian way and are "good ones" also see themselves as living in the non-Indian way. The two, however, are not opposed. Some children rate highly on both the Indian and the non-Indian ways. They are bicultural; that is, they identify with both cultures. Others rate highly on only one. Still others are in the middle range or are low on both.

These children, who are living on reservations, do tend to identify with the Indian way more than with the non-Indian way. More than 70% of them indicated "some" to "a lot" of involvement with Indian culture. About a fourth, however, felt little identification with Indian culture despite living on a reservation and being members of tribes that are actively engaged in Indian activities and events.

The children who are bicultural show the lowest use of alcohol and drugs (Table 9). These children are highly identified with both

Table 9

Cultural Identification and Children's Drug Use

	Bicultural	Only Indian	Only Non-Indian	Others
Child Polydrug	4%	2%	6%	6%
Drug Involved	7%	10%	22%	17%
Alcohol	4%	7%	4%	4%
Not Drug Involved	85%	81%	68%	72%
N =	147	152	115	616

(Total N = 1030)

Chi Square = 23.92, d.f. = 9, p = .005.

Indian and non-Indian cultures. Their families seem to be successful in getting along in both cultures. They are active in Indian affairs, but also do well in non-Indian areas of life. We assume that children in such families feel a greater sense of security and less cultural conflict than other children.

The children who are strongly identified only with Indian culture and have a low identification with non-Indian culture also show a low involvement with drugs, but they may have a very slightly higher involvement with alcohol. These are children who are living on the reservation, in Indian communities, and their families are active in Indian affairs. They apparently feel comfortable with much of the cultural situation that surrounds them. This Indian

cultural identification may relate directly to the higher use of alcohol. Alcohol has been a chronic problem for adults in these tribes for many years. All too many of the Indian adults that they identify with do drink.

The children who identify with only non-Indian ways have a higher involvement with drugs. More than one-fourth of them are drug involved. They may be under the most cultural stress. Their way of handling the conflicting values and attitudes of Indian and non-Indian cultures has been to move away from the Indian way. Despite living on the reservations and in tribes where there are many Indian activities, they do not participate in these activities very much. In this, they are also marking themselves as different from their neighbors, since most of the families do participate in Indian affairs. It could be pointed out that these are not necessarily weak families. Many of these children see their families as "good ones" in the non-Indian way. The families and the children have simply chosen to move away from the Indian way. This may be producing cultural stress for the children because they are in a community that is still, for the most part, observing many aspects of Indian life.

The differences just discussed in the drug use among children of varying cultural identifications are not great, as Table 9 shows. A significant number of children in every cultural group

are involved with drugs, so the strength and nature of cultural identification is not the simple answer to drug use. It is, however, something that needs to be considered.

There has been some tendency to view Indian identification as one end of a pole and non-Indian identification as the other--to identify with one meant rejecting the other. If a choice must be made, the better choice is to follow the Indian way. At least in communities where Native American traditions are generally strong, a high level of involvement and identification with those traditions helps strengthen the child's resistance to drug use. Those rejecting the Indian way in favor of the non-Indian way do not fit into these communities as well, and there is likely to be a higher use of drugs among children. But it is not necessary that a child choose one or the other. Apparently many families are able to be good families in both ways. They can and do deal with both Indian and non-Indian activities and values equally effectively. Their children have the lowest level of drug use.

It is necessary to note that identification with the Indian way is not directly and totally related to whether the family is "traditional." Much of the literature on culture is concerned with a dichotomy between traditional and non-traditional families. Traditional has meant many different things. In some studies, for example, it is determined by language, in others by percentage

of Indian blood. These might or might not be related to a child's identification with the Indian way.

If we did relate drug use to whether a family was traditional, we feel that we would have to identify at least two different kinds of traditional families. One would be a high status family, where the parents were clan leaders, war chiefs, etc. Children of these families would probably call their families "good ones" in the Indian way. They would be like the children from our survey with high Indian identification and would show a somewhat lower use of drugs. The other traditional family would be a low status one. They would speak only an Indian language or be of pure blood, but would have only minimal roles to play in tribal affairs or ceremonies. Children of such families would be more likely to be involved with drugs.

We think that it is unlikely that cultural identification, by itself, determines drug use. The relationship is likely to be more indirect. Cultural identification is related to the family's status and role in the tribe and therefore to the child's pride and confidence in the family. It is that pride and confidence that helps the family be an influence against drugs.

The Family

In our previous studies of drug use among Native American adolescents, we found a higher percentage of broken families among

those young people who were most involved with drugs. In this study of younger children, we found a similar relationship, but it is not as large and may have occurred by chance (Table 10 below). Taking both studies together, however, we believe that if the family is broken, the child is more likely to get involved with drugs.

Table 10

Family Structure and Drug Use

	Both Parents Home	Father NOT Home	Mother NOT Home	Neither Parent Home
Child Polydrug	5%	5%	10%	11%
Drug Involved	13%	19%	12%	19%
Alcohol	5%	5%	6%	3%
Not Drug Involved	78%	70%	72%	67%
N =	642	280	33	67

(Total N = 1022)

Chi Square = 13.35, d.f. = 9, p = .15.

A finding like this needs to be treated with caution. While a broken home may make a child more susceptible to drug use, the majority of children from broken homes do not get involved with drugs. Nearly half of the children in these tribes are from some kind of broken home, yet less than a third of those children are actually drug involved.

Despite the high number of broken homes, most young Indian children do feel that their families care about them. 85% will mark "a lot" to both of the questions, "Does your family care about you?" and, "Does your family care what you do?" But if there is even some doubt, if they mark "some," "not much," or "not at all" to even one of these questions, they are much more likely to get involved with drugs. The following table (11) shows that nearly half of the children who express this kind of doubt use alcohol or drugs.

Table 11

Child's Perception of Family Caring and Drug Use

	Family cares "a lot"	Family cares "some"	Low family care
Child Polydrug	3%	15%	17%
Drug Involved	14%	31%	19%
Alcohol	5%	7%	4%
Not Drug Involved	78%	47%	60%
N =	873	86	58

(Total N = 1017)

Chi Square = 35.96, d.f. = 6, p = .000

When children feel that their families care for them, it does make them less susceptible to drug use, but it does not completely

protect them. 17% of children who feel that their families care for them still get involved with drugs. But when children feel that the family does not care, then there is a much greater chance that they will use drugs. Not many children have these doubts, but of those children, 44% are drug involved and 15% are members of the most serious category of drug abuse, the child polydrug pattern.

These children are in serious trouble. They are only 9-12 years old. They are already using marijuana and inhalants and many are trying uppers or downers. They are beginning a pattern that we feel is likely to lead to steadily increasing drug use during the next few years.

As with the general level of the family's concern about the child, the family's attitudes about drugs have a decided influence on that child's drug use (Table 12). If children say that the family is strongly against drug use, they will tend not to use drugs. Conversely, if there is no perceived attitude against drugs the child is more likely to use them.

The family is clearly important. If the family is broken, there is a slightly greater chance that the child will get involved with drugs, but the feeling that the child has about whether the family cares is the critical variable. The extended family, grandparents, aunts, and uncles, can communicate caring to the child even when there has been a divorce, a separation, or the death of a parent.

Table 12

Child's Perception of Family Caring About Use of Drugs by Drug Use

	A Lot	Some	Low
Child Polydrug	3.4%	7.9%	15.0%
Drug Involved	12.1%	27.2%	17.5%
Alcohol	4.1%	8.4%	1.2%
Not Drug Involved	80.4%	56.5%	66.2%
N =	759	191	80

(Total N = 1030)

Chi Square = 65.77, d.f. = 6, p = .001

When the child feels that the family does care and when that family shows that they are strongly against drugs, that child will only occasionally use drugs and is much less likely to be among those children who are very seriously drug involved.

Deviant Attitudes and Deviant Behaviors

Social norms are against children using drugs. Most children agree with adults that using drugs is wrong. But some children act out against social norms; they engage in antisocial acts of various kinds. They lie, steal, engage in vandalism, and do other things that adults do not like. Do these children also use drugs? Is drug use, for them, one more way of rebelling against social norms?

We asked, on the survey, how wrong it was to lie, cheat, and steal. Children who said it was not very wrong have attitudes that are deviant from social norms. We also asked how often they engaged in these deviant behaviors. The two are not necessarily correlated. There are children, for example, who believe these things are wrong, but still do them.

The children who do lie, cheat, or steal and who do not believe that these things are very wrong are likely to be involved with drugs (Table 13). Half are using drugs and 36% are in the most severe drug use group, the child polydrug pattern. By contrast, children who say they never do these things and who believe that they are very wrong, are not likely to use drugs. 91% are not involved with drugs.

Table 13

Deviant Attitudes, Deviant Behavior (Lie, Cheat, Steal), and Drug Use

	Tolerance and Behavior					
	Very Low on Both	Low Tol. & Bhvr	Others	High Tol.	High Bhvr	High on Both
Child Polydrug	.4%	2%	2%	7%	9%	36%
Drug Involved	7%	43%	13%	18%	19%	17%
Alcohol	2%	9%	5%	4%	7%	0%
Not Drug Involved	91%	46%	80%	72%	65%	47%
N =	265	44	258	138	289	36

(Total N = 1030)

Chi Square = 160.47, d.f. = 15, p = .001.

The results would be very consistent if it were not for one anomalous finding. There is a group of children who believe these things are wrong, but not extremely wrong and who also engage in a very little deviant behavior: they very occasionally lie or cheat or steal something. 54% of those children use some kind of drug, most of them either marijuana or inhalants. Very few of them, however, are in the most serious drug use group.

The children in the extreme non-deviant group are apparently showing a very stereotyped response. They know right from wrong and behave accordingly. When children are a little less extreme, like those described above, they seem to be saying, "Usually, I agree with adult norms--I am only a little doubtful and only occasionally do something "wrong." But I don't see much wrong with using some marijuana or sniffing something once in a while." We need to know more about this response. These children are generally conforming to adult norms. Perhaps they feel that a little use of drugs is not really against those norms. If so, then they are getting a message from adults that could do them a lot of harm. They are very young and are starting a drug use pattern that could lead them deeper into trouble as they get older.

A prevention program that shows how much adults are against drug use by children may reach this group of children. They are in touch with and usually responsive to social norms. But it might be very difficult to design such a program. This particular group of

children may be very realistic about the true meaning of social norms. "Cheating" is bad, for example, but it is done once in a while. Similarly, "drug use" is bad, but they see adults doing it once in a while. These children may be modelling the actual social norms too well.

We may need to be much more concerned about the child who is in severe conflict with society--the one with a high tolerance for deviance and a high level of deviant behavior. These children are acting out in many ways and do not believe that it is very wrong to do so. One of the ways is to use multiple drugs, alcohol, inhalants, marijuana, and even "pills."

We all know some of these children. The "Smith" boys are always in trouble. They steal from the local store. They run wild at night and break windows. They shoot cats. As soon as they can they will drop out of school. The punishment and rejection that they receive for other acts--stealing, vardalism, etc.--may drive them further from society and further into drugs.

Other Children--Friends, Brothers, and Sisters

While the family, the school, and personal problems can set the stage for drug use, it is other children that actually start the child on drugs. Other children provide the drugs, teach how to use them, and encourage continuing drug use.

On the other hand, friends can also have a positive influence. Children who do not use drugs tend to have friends who do not use

drugs, and those friends would try to stop them if they started to use drugs. This influence by other children is very powerful. Children who are using drugs nearly always have friends who use drugs in about the same way that they do (Tables 14, 15, and 16).

Among the children who influence drug use are older children in the family. These may be older brothers and sisters, or in an extended family, slightly older aunts and uncles who are living in the same house. They encourage drug use by example, using drugs in front of younger children. They are also likely to get drugs for younger children. The influence is then hard to escape.

Children influence each other's drug use in two ways. One is by directly encouraging use, asking other children to use drugs with them and providing drugs for them. The other way is by applying social pressure against drugs, being willing to stop their friends from using drugs. The two are related to each other, but not perfectly. In most cases, if friends are encouraging use of drugs, they are not going to apply social pressure to stop use of drugs. But a child can have more than one group of friends, so that one group is encouraging use and another group is working to stop drug use.

Encouragement is measured on the survey by asking how often other children suggest using drugs and whether older brothers or sisters get drugs for children. These variables are highly related

to the number of friends who use drugs, what drugs the friends use, and how much those friends use drugs.

Social pressure against using drugs is measured on the survey by asking whether friends would stop a child from using drugs and whether the child would stop his or her friends from using drugs. Encouragement and social pressure work against each other to predict drug use. The following pages have a set of three tables that show how this works. For each of the three major drugs, the combination of encouragement to use drugs and social pressure against using drugs predicts very accurately whether a child is likely to use that drug.

The most important factor in protecting a child from drug use is whether that child has low encouragement from other children. When there is low encouragement, well over 90% of the children have never tried a drug. If there is also strong social pressure against using a drug, more than 97% of the children will not even try it. This finding shows how terribly important other children's encouragement to use drugs can be; without it there is almost no significant use of drugs.

When there is some encouragement from one group of friends, then social pressure against the use of drugs by other friends becomes very important. The graph for alcohol use, for example, shows how dramatically this social pressure can affect drug use. The top section of the graph shows what happens when there is high

Table 14

Peer Encouragement and Social Pressure Against Use of Alcohol

Encouragement by Other Children	Social Pressure Against Use of Alcohol	N	Heavy Use	Some Social Use	Family Use or Tried Alcohol	No Use
	Low	165	48%	23%	4%	25%
High Encouragement	Med.	99	11%	32%	9%	48%
	High	51	0%	6%	6%	88%
	Low	28	18%	29%	7%	46%
Med. Encouragement	Med.	32	0%	31%	9%	59%
	High	17	0%	0%	6%	94%
	Low	148	1%	3%	3%	93%
Low Encouragement	Med.	124	4%	4%	4%	88%
	High	441	0%	0%	1%	98%

Table 15

Peer Encouragement and Social Pressure Against Use of Marijuana

Encouragement by Other Children	Social Pressure Against Use of Marijuana	N	Heavy Use	Inhalant Use	Tried 1-2 Times	No Use
High Encouragement	Low	168	50%	28%	36%	18%
	Med.	60	17%	48%	8%	27%
	High	58	15%	10%	12%	67%
Med. Encouragement	Low	26	15%	31%	4%	50%
	Med.	19	0%	37%	10%	52%
	High	13	8%	23%	15%	54%
Low Encouragement	Low	156	1%	3%	4%	91%
	Med.	72	0%	3%	6%	92%
	High	554	0%	1%	2%	97%

Table 16

Peer Encouragement and Social Pressure Against Use of Inhalants

Encouragement by Other Children	Social Pressure Against Use of Inhalants	N	Heavy Use	Inhalant Use	Tried 1-2 Times	No Use
High Encouragement	Low	74	28%	26%	4%	42%
	Med.	41	27%	17%	10%	46%
	High	39	10%	5%	5%	80%
Med. Encouragement	Low	14	14%	21%	7%	58%
	Med.	16	0%	38%	6%	56%
	High	15	0%	7%	0%	93%
Low Encouragement	Low	227	1%	4%	1%	94%
	Med.	120	1%	4%	2%	93%
	High	583	0%	1%	1%	98%

encouragement to use alcohol: generally the use of alcohol is fairly high. Most of the children who have a high level of encouragement, also have only a low level of social pressure against using alcohol (Line 1 on Table 14). With high encouragement and little pressure against its use, nearly half of the children use alcohol heavily, enough, in this case, to have gotten drunk several times or so drunk that they have fallen down or been sick.

By contrast, there are a few children who have high encouragement to use alcohol by one group of friends and another group of friends who would apply a lot of social pressure to stop them from using alcohol (line 3 on Table 14). These children, despite the highest level of encouragement, do not use alcohol. None of them have ever been drunk, and 88% have never even tried alcohol.

The same pattern can be seen for the other drugs. If there is low encouragement to use a drug by other children, then there is very little use of that drug. If there is encouragement to use the drug, then it is very important that other friends would apply social pressure to stop its use.

One question that might be asked is whether this relationship is a cause or an effect: Does encouragement by other children lead to drug use, or do children who use drugs merely seek out friends who will support their use of drugs? We believe that both are occurring at the same time and in a continuing process. Children first try a drug when their friends introduce them to it and show

them how to use it. If other friends are strongly against drug use, then the child can resist. If not, the child will try the drug.

If the drug experience is not too noxious, if the child has social or personal needs that the drug is meeting, and if friends continue to press drug use, then use of the drug increases. As drug use increases, the child moves away from friends who would try to stop it, and seeks out children who are also using drugs. Thus, the strong relationship between drug use and attitudes of peers is both a cause and an effect of drug use.

The relationship is so high that this single area shows more potential for prevention than any other that we have discussed. Instead of focusing prevention programs on personal use of drugs, perhaps programs should be aimed at changing attitudes about involving others with drugs. The slogans might be, "Don't turn your brother on!" or "Protect your sister!" The message to older youth might be, "Your friends can make their own choice about drugs--but don't let them turn on other kids!" There is no way of knowing how effective such a program might be at this time, but if done well, it might be more effective than present approaches.

Another possibility that must be considered is doing something about groups of children that are supporting each other's drug use. This may be very difficult since children are very defensive about their friends and resist pressure to change them. But families, schools, and social programs for children should consider doing whatever can be done to break up mutually destructive groups.

One way of increasing social pressure against drugs for these young children might be traditional programs emphasizing the harm drugs do. These kinds of programs have been found to have minimal effect with older adolescents, but among older adolescents, there is little or no relationship between attitudes toward "harm" and social pressure against drug use. Among these younger children, the child who thinks drugs will do harm is still willing to stop friends from using that drug. Such programs must be realistic and reasonable: unrealistic claims of drug damage only make children reject other advice about drugs. Further, since the relationship between social pressure and the belief that drugs harm you decreases rapidly as children get older, this is, at best, a preventive measure limited to the younger age groups.

Seeing to it that children are involved with several different groups of friends might also help. The child may get encouragement to use drugs from one group, but if there is strong social pressure against drug use in another group, it may prevent or limit use.

So too may programming aimed directly at increasing social pressure against drug use. Modelling films showing a child stopping a good friend from using a drug and being rewarded by that friend might be useful. Programs emphasizing sanctions, such as, "If she is really your friend, you would stop her," may also reach young children.

The importance of these peer relationships cannot be exaggerated. While a strong family and a good school can help, a child's friends will still have a very powerful influence on that child's behavior, so strong that it may undo anything else that has been done to protect that child from drugs.

The School

In our studies of adolescent drug use we have found a consistent relationship between school adjustment and drug use. Young people with poor school adjustment have been more likely to be involved with drugs.

There are two aspects to school adjustment: whether the student is doing well in school (getting good grades) and whether the student likes school. While the two are related, they are not exactly the same thing. Table 17 shows how school adjustment relates to drug use. There is a clear relationship between school adjustment and use of drugs by these 9-12 year old children. If they both like school and are doing well in school, the percentage who are using drugs is very low. Of the children who dislike school and are doing poorly, nearly one-fourth are in the most serious drug use group, the child polydrug pattern.

We know that Native American children have more than the usual amount of difficulty in adjusting to school. The language problem has already been mentioned. Teachers, because of high turnover,

Table 17

School Adjustment and Drug Use

	High Success AND High Liking	High Liking OR High Success	Others	Low Liking OR Low Success	Low Success AND Low Liking
Child Polydrug	2%	4%	6%	11%	28%
Drug Involved	7%	16%	34%	27%	18%
Alcohol	3%	6%	6%	6%	3%
Not Drug Involved	89%	74%	54%	56%	51%
N =	342	456	67	118	39

(Total N = 1022)

Chi Square = 129.22, d.f. = 12, p = .0000.

may have limited experience in teaching, particularly in the teaching of Native Americans. Teachers and students may have cultural conflicts as well. Anglo culture tends to emphasize competitiveness where many Indian tribes view it as somewhat "impolite." Many Indian cultural attitudes and beliefs are viewed as "superstition" by Anglo teachers. Physical and emotional illness have different roots and different causes in Anglo and Indian cultures. As a consequence of these conflicts and deficiencies, the drop-out rate for Native American children once they reach high school is exceptionally high.

Given these problems, it is surprising how many of these young children do like school and feel that they do well in school. Nearly three-fourths of the children say they either like school or do well in school or both. However, they must change their minds very rapidly. The dropout rate begins to increase at about this time and continues to go up through the next six years, eventually getting high enough so that many of these children who now have positive feelings will change their minds and leave school.

Our data convinces us that the school can be a very important factor in either preventing or encouraging drug use. The child who begins to do badly in school and then is rejected or punished by the teachers for not doing well or for behavior problems, begins to develop a negative self-concept, feelings of worthlessness and uselessness. The child is likely to turn away from teachers or other adults who would advise against drug use and turn toward other children who are in trouble--children who are more likely to encourage drug use.

On the other hand, children who do well and who behave well in school, tend to build good relationships with the teachers. They are more likely to listen and believe it when the teachers advise against use of drugs. They make friends with other children who are also well adjusted in school and who are likely to discourage drug use. They are more likely to feel a sense of pride and self worth and have less need to turn to drugs. This very close relationship between school adjustment and feelings of self worth is shown in Table 18.

Table 18

Mean Scores for Feelings of Self Worth as They Relate to School Adjustment

Self Worth Scores (Positive Self Regard)	High Success AND High Liking	High Liking OR High Success	Others	Low Liking OR Low Success	Low Success AND Low Liking
Mean	9.4	7.7	6.8	5.7	5.3
Standard Deviation	2.9	2.8	2.5	2.8	3.3
N	364	507	74	133	47

(Total N = 1125)

One-way ANOVA: F = 57.78, d.f. = 4/11.24, p = .0000. (adjust for unequal N)

Our findings on the two aspects of school adjustment have important implications for the structuring of drug abuse prevention programs. These programs are often located in the school, because that is where most children can be reached. Unfortunately, it is just those children who are in trouble in the school, the ones that the school is least likely to be able to influence, who are most in danger of being involved with drugs. A drug prevention program might be better aimed first at improving school adjustment, both helping children do better in school and helping them retain their liking for school. These efforts must begin in the early grades before the liking for school and the self-concept are seriously eroded.

Personal Adjustment

Nearly six years ago we started trying to assess personal adjustment by using standard personality test items. Scores on those tests did not relate to drug use. Nevertheless, we saw enough children who were using drugs and who seemed to have emotional problems that we continued trying to find items that would tap those problems and show the relationship with drug use that we were convinced was there.

The present items are a result of that search. They are very simple and direct questions, easy for children to answer. Cluster analysis shows separate clusters that touch on different kinds of feelings that the children are experiencing. There are two main clusters of items that are not very highly correlated with each other. They are self-esteem (feelings of pride and liking oneself) and depression (feelings of being sad, lonesome and nervous). Near these two are smaller item clusters that are slightly different but rather closely related to one of the two clusters. Near self-esteem is a social adjustment cluster (being well liked). Near depression are three clusters: blame (feeling people blame you for things), rejection (feeling left out), and alienation (feeling picked on or made fun of). The intercorrelations of the personal adjustment scales appear in Table 19.

There are relationships between these personal adjustment scores and drug use. Table 20 shows the mean scores for the six item clusters and how they relate to drug use.

Table 19

Intercorrelations of Personal Adjustment Scales

	Self Esteem	Social Adjustment	Depression	Rejection	Alienation
Social Adjustment	.58				
Depression	-.06	-.03			
Rejection	-.26	-.17	.52		
Alienation	-.15	-.16	.49	.56	
Blame	-.12	-.09	.54	.41	.43

Table 20

Mean Scores for Personal Adjustment and Drug Use

	Self Esteem	Social Adjustment	Depression	Rejection	Blame	Alienation
Child Polydrug	6.51	5.88	7.32	2.86	3.58	4.41
Drug Involved	6.78	6.32	5.96	2.30	3.55	3.36
Alcohol	7.51	6.65	6.73	2.55	3.67	4.43
Not Drug Involved	8.21	6.74	5.56	1.98	3.02	3.49
F =	15.46	4.69	4.07	6.08	3.72	6.12
d.f. =	3/1000+					
p =	.000	.003	.007	.000	.01	.000

The higher the self-esteem and the better the social adjustment, the less likely the child is to use drugs. Children with the child polydrug pattern show the lowest self-esteem and the poorest social adjustment scores. The lower self-esteem and social skills among drug-using children may be either a result of drug use or a cause of drug use. There is a good chance that it is a cause--that the problems in adjustment come first and that drug use is, at least partly, a result of these problems.

Our other studies have included questions asking about reasons for drug use, and one of the major reasons that children give is that drugs help them feel better and help them get along with other kids. It may be even more fundamental than that. Children with a lot of pride do not need drugs. They feel good about themselves and about their world. They may also be stronger and less susceptible to social pressure, they are strong enough to say "no." Children with a lot of friends also don't have to use drugs to make friends. So self-esteem and good social skills can help children avoid drugs.

The depression scale includes items about feeling sad, lonesome, worried, and low. One hypothesis about the use of drugs is that some children are taking them as a method for self-medication, that they feel bad and are using drugs to make themselves feel better. In our other studies of older children there are children who confirm this; they say that they are taking drugs in order to make themselves feel better and to get rid of unhappy feelings. At least some of

these younger children are probably doing the same thing. Alcohol, for example, may give the child some immediate release from these feelings. The first response to a mild dose of alcohol is often reduced anxiety and a mild euphoria.

The other scales--blame, rejection, and alienation--are related to depression, but deal with somewhat different feelings. Children who feel rejected think that they are left out of things and hate themselves. Children who feel blamed, think that people get mad at them and that they are blamed for things they don't do. Alienated children feel that people pick on them and that other kids hate them and make fun of them. Children who have any of these feelings are more likely to be involved with drugs. Some of these feelings may be because they are using drugs--people may be rejecting and blaming them for their drug use. But children who feel that others are against them may turn to drugs. Drugs are often taken with other kids, so for the child who feels rejected they offer an opportunity to be part of a group for a short time. Drugs are also a way of reacting angrily against a society that they feel is rejecting them, a kind of "I'll show you!" attitude.

What can be done to prevent those feelings from developing in the first place? A strong feeling of pride and well-being can help protect a child from drugs. The family can also give the child a feeling of security. When the child is loved and knows it, a feeling of being worthwhile develops. The school can help children feel

successful and feel good about themselves. The tribe can show children how much pride they can take in being Indian. The community can be a good one to live in, one that children can feel proud to be a part of. All of these can help children develop a sense of self-worth and pride, helping to reduce drug use.

When we speak of those children who experience rejection, blame, and alienation, we are talking about a fairly large number of children. About a fourth of the children feel they are blamed for things a lot, but this feeling is quite common among children. The more serious problems are less frequent. About 13% feel strong depression, about 13% feel considerable alienation, and about 17% feel a strong lack of self-worth. Since there are relatively high correlations among these scales, many children are having more than one of these problems, so the total number of children who are experiencing some form of fairly severe adjustment problem is slightly more than 25%.

Some help for these children could come from a good counselor, one who could help them learn that they are worthwhile people. There are educational programs that also have a potential for teaching children how to get along better with others, that teach them how to do things and what to do about bad feelings. But most of these programs have been used only with non-Indian children. They would need to be redesigned and tested so that they were culturally appropriate and so that pride in being Indian could be built-in as well.

Some help could come from traditional healers. Some of these children could have violated taboos. Others have had culturally "bad" dreams. Others have had experiences that have led directly or indirectly to emotional problems. These might be obvious to an Anglo counselor, e.g., a family death, but they might be experiences that have unique cultural roots, such as eating an animal that was struck by lightning. Traditional healers can diagnose these kinds of problems and provide ceremonies that get rid of the problem and allow the child to start a new life.

A serious effort to provide culturally appropriate mental health treatment programs should be made. A fourth of the children say that they are experiencing some kind of personal adjustment problem. While there are many other reasons for drug use that also have to be dealt with, drug use is, for at least some of these children, a reflection of those problems.

Feelings About the Future

Four questions on the survey asked what the future would be like. Will you go to college? Will you have a good job when you grow up? Will you graduate from high school? Will you make enough money to buy the things that you want? When we asked these same questions of adolescents, they clustered together, showing that they were measuring a common underlying characteristic, expectancy about the future. That characteristic, measured by a total score on the four items, was related to drug use.

Younger children do not respond in the same way to these questions. None of the questions correlated highly enough with any of the others to form a cluster. Therefore we had to look at each of them separately. Nearly every child indicated that he or she expected to graduate from high school and expected to have enough money to buy things. That is why those two questions could not be related to the other questions or to drug use. The other two questions do relate to drug use (see Table 21).

Children who do not expect much from the future are much more likely to turn to drugs. Very few of the children who think they will go to college or who think they will have a good job when they grow up are in the child polydrug pattern. By contrast, one fourth of the children who expect to have no job at all are already using multiple drugs. When the future offers little hope, why not seek whatever pleasure you can find right now?

Table 21

Feelings About the Future and Drug Use

	Will you go to college?		
	Yes, I will	Maybe	No
Child Polydrug	3%	7%	11%
Drug Involved	8%	24%	14%
Alcohol	4%	5%	6%
Not Drug Involved	85%	64%	69%
N =	508	430	85

(Total N = 1023)

Chi Square = 67.72, d.f. = 6, p. = .000

	Will you have a good job when you grow up?			
	Yes, very good	Yes, good	No, not very good	No, no job at all
Child Polydrug	3%	6%	19%	25%
Drug Involved	10%	24%	27%	17%
Alcohol	5%	4%	4%	4%
Not Drug Involved	82%	66%	50%	54%
N =	598	374	26	24

(Total N = 1022)

Chi Square = 80.42, d.f. = 9, p = .000

DO NOT PUT YOUR NAME ANYWHERE ON THIS PAPER

Please answer all the questions as well as you can. Don't worry about spelling or being neat, just give the best answers you can. No one will find out what you say, so please be honest.

1979

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Please check the right answer or write out the answer to the questions.

1. _____ Boy
   _____ Girl

2. How old are you? _____

3. Are you . . .

   _____ Indian
   (What tribe? _____)
   _____ Anglo or white
   _____ Spanish or Mexican-American
   _____ Black
   _____ Other (What? _____)

4. What grade are you in? _____

5. Does your father live at home with you?

   _____ Yes
   _____ No
   _____ My father died

6. Does your mother live at home with you?

   _____ Yes
   _____ No
   _____ My mother died

7. How many older brothers do you have? _____

8. How many older sisters do you have? _____

9. What religion are you? _____

10. Do you take part in your religion?

    _____ Not at all
    _____ A little
    _____ Some
    _____ A lot

11. Have you ever tried beer or wine?

    _____ Yes
    _____ No

12. How often do you drink beer or wine?

    _____ I never drink it
    _____ 1 or 2 times a year
    _____ 1 or 2 times a month
    _____ Almost every week
    _____ More than that

13. Is it bad to drink beer or wine?

_____ A lot
_____ Some
_____ Not much
_____ No

14. When do you drink beer or wine?

_____ I do not drink
_____ Just on weekends or holidays
_____ During the week and on weekends or holidays
_____ Almost every day

15. Where do you drink beer or wine?

_____ I never drink it
_____ Only at home with my family
_____ With other kids when no parents are around
_____ By myself and with other kids

16. Does your family care if you drink beer or wine?

_____ A lot
_____ Some
_____ Not much
_____ They don't care at all

17. How do you like to drink beer or wine?

_____ I never do it
_____ Just a small taste
_____ Just enough to feel it a little bit
_____ Enough to feel it a lot

13. Have your friends ever asked you to drink beer or wine with them?

_____ Never
_____ Sometimes
_____ A lot

19. How many of your friends drink beer or wine?

_____ None
_____ 1 or 2
_____ A lot of them

20. Has your brother or sister ever gotten beer or wine for you?

_____ Never
_____ Sometimes
_____ A lot

21. Have you ever gotten really drunk so you fell down or got sick?

_____ Never
_____ 1 or 2 times
_____ 3 or more times

22. In the past two months, how often did you get drunk?

_____ I did not drink
_____ Drank some, but never enough to get drunk
_____ Got drunk 1 or 2 times
_____ Got drunk 3 or more times

23. Would your friends try to stop you from drinking beer or wine?

_____ A lot
_____ Some
_____ Not much
_____ No

24. Would you try to stop your friends from drinking beer or wine?

_____ A lot
_____ Some
_____ Not much
_____ No

25. Would your friends try to stop you from getting drunk?

_____ A lot
_____ Some
_____ Not much
_____ No

26. If you drink beer or wine, where do you get it?

_____ Do not drink
_____ Friends give it to me
_____ Brother or sister gives it to me
_____ Buy it from other kids
_____ Take it from home
_____ Buy it from liquor store or bar
_____ Other (Where? _____)

27. Would your family try to stop you from getting drunk?

_____ A lot
_____ Some
_____ Not much
_____ No

28. Do you smoke cigarettes?

_____ No, never
_____ I tried them once or twice
_____ I smoke a little
_____ I smoke a lot

29. Have you ever sniffed something to get high?

_____ Yes
_____ No
_____ I don't know what you mean

30. How old were you when you first sniffed something to get high?

_____ Never sniffed anything

I was _____ years old

31. What did you sniff the very first time?

_____ Never sniffed anything

I sniffed _____

32. During the first year you sniffed, how often did you do it?

_____ I never sniffed anything
_____ A few times that year
_____ Almost every week
_____ Almost every day

33. What do you sniff now?

_____ I never do it now

I sniff _____

_____

_____

34. How often do you sniff something to get high?

_____ I never do it
_____ A few times a year
_____ Almost every week
_____ Almost every day

35. Is it bad to sniff things to get high?

_____ A lot
_____ Some
_____ Not much
_____ No

36. When do you sniff to get high?

_____ I never do it
_____ Just on weekends or holidays
_____ During the week and on weekends or holidays
_____ Almost every day

37. Where do you sniff to get high?

_____ I never do it
_____ A little with other kids
_____ A lot with other kids
_____ By myself and with other kids

38. Does your family care if you sniff things to get high?

_____ A lot
_____ Some
_____ Not much
_____ They don't care at all

39. How do you sniff to get high?

_____ I never do it
_____ Just enough to feel it a little bit
_____ Enough to feel it a lot
_____ Until I pass out or come close to it

40. Have your friends ever asked you to sniff something with them?

_____ Never
_____ Hardly ever
_____ Sometimes
_____ A lot

41. How many of your friends sniff things to get high?

_____ None
_____ 1 or 2
_____ A lot of them

42. Would your family try to stop you from sniffing something to get high?

_____ A lot
_____ Some
_____ A little
_____ No

43. Has your brother or sister ever given you something to sniff?

_____ Never
_____ Hardly ever
_____ Sometimes
_____ A lot

44. Would you try to stop your friends from sniffing something to get high?

_____ A lot
_____ Some
_____ Not much
_____ No

45. Would your friends try to stop you from sniffing something to get high?

_____ A lot
_____ Some
_____ Not much
_____ No

46. If you sniff something to get high, where do you get it?

_____ Do not sniff anything
_____ Friends give it to me
_____ Brother or sister gives it to me
_____ Take it from home
_____ Buy it
_____ Steal it
_____ Other (Where? _____)

47. Have you ever smoked marijuana (pot or grass)?

_____ Yes
_____ No
_____ I don't know what it is

48. How old were you when you first tried pot or grass?

_____ I never tried it

I was _____ years old

49. How often do you use pot or grass?

_____ I never use it
_____ A few times a year
_____ Almost every week
_____ Almost every day

50. Is it bad to use pot or grass?

_____ A lot
_____ Some
_____ Not much
_____ No

51. When do you usually use pot or grass?

_____ I do not use it
_____ Just on weekends or holidays
_____ During the week and on weekends and holidays
_____ Almost every day

52. Does your family care if you use pot or grass?

_____ A lot
_____ Some
_____ Not much
_____ No

53. How do you use pot or grass?

_____ I do not use it
_____ Just a little with other kids
_____ A lot with other kids
_____ By myself and with other kids

54. Have your friends ever asked you to use pot or grass with them?

_____ Never
_____ Sometimes
_____ A lot

55. How many of your friends use pot or grass?

_____ None
_____ 1 or 2
_____ A lot of them

56. Has your brother or sister ever given you pot or grass?

_____ Never
_____ Sometimes
_____ A lot

57. Would you try to stop your friends from using pot or grass?

_____ A lot
_____ Some
_____ Not much
_____ No

58. Would your friends try to stop you from using pot or grass?

_____ A lot
_____ Some
_____ Not much
_____ No

59. Will using pot or grass hurt you?

_____ A lot
_____ Some
_____ Not much
_____ No

60. If you have used pot or grass, where did you get it?

_____ I never have used it
_____ Friends give it to me
_____ Brother or sister gives it to me
_____ Buy it
_____ Take it from home
_____ Other (Where? _____)

61. Would your family try to stop you from using pot or grass?

_____ A lot
_____ Some
_____ Not much
_____ No

62. Did you ever take pills that were NOT given to you by a doctor or your family?

_____ Yes
_____ No

63. How often did you take pills not given to you by a doctor or your family?

_____ I never took any
_____ 1 or 2 times
_____ Several times
_____ As often as I can get them

64. What kind of pills did you take?

I took _____

_____ I don't know
_____ Never took any

65. Is it bad to take pills that are not given to you by a doctor or by your family?

_____ A lot
_____ Some
_____ Not much
_____ No

66. Does your family care about you?

_____ A lot
_____ Some
_____ Not much
_____ They don't care at all

67. Is it bad to tell a lie?

_____ A lot
_____ Some
_____ Not much
_____ No

68. Do you want people to think you are a good person?

_____ A lot
_____ Some
_____ Not much
_____ No

69. Do you get good grades?

_____ Very good
_____ OK
_____ Not very good
_____ Bad

70. Is it bad to steal?

_____ A lot
_____ Some
_____ Not much
_____ No

71. Do you want your family to think you are a good person?

_____ A lot
_____ Some
_____ Not much
_____ No

72. Do you want other kids to think you are a good person?

_____ A lot
_____ Some
_____ Not much
_____ No

73. Does your family care what you do?

_____ A lot
_____ Some
_____ Not much
_____ They don't care at all

74. Is it bad to skip school?

_____ A lot
_____ Some
_____ Not much
_____ No

75. How well are you doing in school?

_____ Very well
_____ OK
_____ Not very well
_____ Bad

76. I like myself.

_____ A lot
_____ Some
_____ Not much
_____ No

77. I like my teachers.

_____ A lot
_____ Some
_____ Not much
_____ No

78. I like school.

_____ A lot
_____ Some
_____ Not much
_____ No

79. I am a good student.

_____ Very good
_____ OK
_____ Not very good
_____ Bad

80. I am good looking.

_____ A lot
_____ Some
_____ Not much
_____ No

81. I am lonesome.

_____ A lot
_____ Some
_____ Not much
_____ No

82. I feel bad.

_____ A lot
_____ Some
_____ Not much
_____ No

83. I get blamed for things I don't do.

_____ A lot
_____ Some
_____ Not much
_____ No

84. People get mad at me.

_____ A lot
_____ Some
_____ Not much
_____ No

85. I am nervous.

_____ A lot
_____ Some
_____ Not much
_____ No

86. I cheat in school.

_____ A lot
_____ Some
_____ Not much
_____ No

87. Other kids hate me.

_____ A lot
_____ Some
_____ Not much
_____ No

88. I'm good at games.

_____ A lot
_____ Some
_____ Not much
_____ No

89. I do things my teachers don't like.

_____ A lot
_____ Some
_____ Not much
_____ No

90. I feel sad.

_____ A lot
_____ Some
_____ Not much
_____ No

91. I get blamed when things go wrong.

_____ A lot
_____ Some
_____ Not much
_____ No

92. School is fun.

_____ A lot
_____ Some
_____ Not much
_____ No

93. I feel low.

_____ A lot
_____ Some
_____ Not much
_____ No

94. My teachers like me.

_____ A lot
_____ Some
_____ Not much
_____ No

95. Other kids like to play with me.

_____ A lot
_____ Some
_____ Not much
_____ No

96. I get tense and jumpy.

_____ A lot
_____ Some
_____ Not much
_____ No

97. People pick on me.

_____ A lot
_____ Some
_____ Not much
_____ No

98. Other kids like me.

_____ A lot
_____ Some
_____ Not much
_____ No

99. I am a good person.

_____ A lot
_____ Some
_____ Not much
_____ No

100. I lie to people.

_____ A lot
_____ Some
_____ Not much
_____ No

101. Talking to strangers is hard for me.

_____ A lot
_____ Some
_____ Not much
_____ No

102. I do bad things.

_____ A lot
_____ Some
_____ Not much
_____ No

103. I am proud of myself.

_____ A lot
_____ Some
_____ Not much
_____ No

104. Making new friends is hard for me.

_____ A lot
_____ Some
_____ Not much
_____ No

105. I steal things.

_____ A lot
_____ Some
_____ Not much
_____ No

106. I am lucky.

_____ A lot
_____ Some
_____ Not much
_____ No

107. Other kids make fun of me.

_____ A lot
_____ Some
_____ Not much
_____ No

108. Other kids like to be with me.

_____ A lot
_____ Some
_____ Not much
_____ No

109. I am shy.

_____ A lot
_____ Some
_____ Not much
_____ No

110. I am religious.

_____ A lot
_____ Some
_____ Not much
_____ No

111. I am left out of things.

_____ A lot
_____ Some
_____ Not much
_____ No

112. I like to play jokes.

_____ A lot
_____ Some
_____ Not much
_____ No

113. Do you speak an Indian language?

_____ Yes, very well
_____ Some
_____ A few words
_____ Not at all

114. Does your family teach you about Indian things?

_____ A lot
_____ Some
_____ Not much
_____ No

115. Do you take part in Indian activities and events?

_____ A lot
_____ Some
_____ Not much
_____ No

116. Does your family take part in Indian activities and events?

_____ A lot
_____ Some
_____ Not much
_____ No

117. Does your family live by or follow the Indian way?

_____ A lot
_____ Some
_____ Not much
_____ No

118. Do you live by or follow the Indian way?

_____ A lot
_____ Some
_____ Not much
_____ No

119. Does your family live by or follow the non-Indian way?

_____ A lot
_____ Some
_____ Not much
_____ No

120. Do you live by or follow the non-Indian way?

_____ A lot
_____ Some
_____ Not much
_____ No

121. Do you want to speak an Indian language?

_____ Very much
_____ Some
_____ Not much
_____ Not at all

122. Do you want to know Indian legends and stories?

_____ Very much
_____ Some
_____ Not much
_____ Not at all

123. Do you take part in Indian religious ceremonies?

_____ A lot
_____ Some
_____ Not much
_____ No

In some schools we will come back in a few years to find out what has happened.

So that we can compare answers, without knowing the names of the students, we have worked out a code.

This is what we would like you to do.

1) Write the month of your birthday. _____

2) Write the last letter of your first name. _____

3) Write the last letter of your last name. _____

4) Write the first letter of your mother's first name. _____

5) Write the first letter of your father's first name. _____

In the following questions, you can check as many answers as are right.

124. Why do you get drunk? (Check all that are right.)

_____ I never get drunk
_____ It makes me feel good
_____ It makes me less sad
_____ To be with other kids
_____ Nothing else to do around here
_____ Because I'm no good
_____ I like the feeling I get
_____ To get rid of unhappy feelings
_____ Because other kids do it
_____ Because I'm bored
_____ Because nobody likes me

125. Why do you sniff things to get high? (Check all that are right.)

_____ I never sniff
_____ It makes me feel good
_____ It makes me less sad
_____ To be with other kids
_____ Nothing else to do around here
_____ Because I'm no good
_____ I like the feeling I get
_____ To get rid of unhappy feelings
_____ Because other kids do it
_____ Because I'm bored
_____ Because nobody likes me

126. What is your future going to be like? (Check all that are right.)

_____ I will have fun
_____ Good things will happen to me
_____ I will be sick a lot
_____ Bad things will happen to me
_____ I will have a good job
_____ I will quit school
_____ I will get in trouble
_____ I will have a lot of money
_____ I will be poor
_____ I will live a long time

When I answered the questions about drinking . . .

_____ I was very honest
_____ I said I drink more than I really do
_____ I said I drink less than I really do

When I answered the questions about sniffing . . .

_____ I was very honest
_____ I said I sniff more than I really do
_____ I said I sniff less than I really do